Exhibit T
Walker Baptist Medical Center Records dated 7/31/03

52

WALKER BAPTIST MEDICAL CENTER

EMERGENCY PHYSICIAN RECORD
Psych Disorder, Suicide Attempt, Overdose (5)

BARRON TOMMY
SOUTHERN MEDICAL GRO 07/31/03 [redacted]
MR: 0246796 M W 046
PT: 9609149-1 JLP ED 02 L

TIME SEEN: 0302 ROOM: ____ __ EMS Arrival
HISTORIAN: patient __spouse __paramedics ____
AGE ____ (M) / F ____
__HX / __EXAM LIMITED BY: ____

HPI chief complaint(s): AMS

Suicidal Thoughts Depression
Agitated Hallucinating
____
Onset- ____
____
Worsened since- ____
severity-
mild moderate severe
____

Suicide Attempt
Self-Injury
Intentional Drug Overdose
Accidental Drug Ingestion
____
____
When? ____
____

context: ____
situational problems
related to: spouse / parent / son / daughter / significant other
work / lost job / school / legal problems
No Job
____
____

current/associated complaints:
depressed / angry / frustrated / agitated / hostile / paranoid
____
confused / hallucinating ____
Drinop
suicidal thoughts / specific plan / gesture or attempt ____
____
____
Ingestion (see list below) ____
suicide attempt wanted to "escape" accidental will not answer
____
__incised / abraded wrist (R / L) ____
____

timing

LIST OF SUBSTANCES INGESTED (if applicable)

name	strength	# taken	when taken
acetaminophen Y / N			
aspirin Y / N			
ethanol Y / N			
Alcohol			
XANAX			

"RESCUE FACTOR" (if suicide attempt)-
How did ingestion/other acts come to attention?
Pt. called Ambulance
____
Arrived by: __private car __ambulance (who called?)
__police *patient spouse* ____
Recently seen/treated by doctor ____
____
____

ROS

PULMONARY & CVS
__cough
__trouble breathing
__chest pain
____

NEURO & EYES
__headache
__visual disturbance
____

GI / GU
__abdominal pain
__nausea
__vomiting
__diarrhea
__problems urinating
____

SKIN & LYMPH & MS
__skin rash / swelling
__joint pain
____

☐ all systems neg. except as marked

PAST HISTORY __negative

__prior suicide attempt
__psychiatric problems
depression bipolar disorder
schizophrenia other
__other problems

__cardiac disease
__hypertension
__diabetes *insulin / oral / diet*
__lung disease
__HIV / AIDS

Surgeries: NV
__tonsillectomy __appendectomy
__cholecystectomy __hysterectomy

Medications __none __see nurses note
Tegretol
Prinivil

Allergies NKDA
__see nurses note

SOCIAL HX smoker ____ drugs ____
recent alcohol use / binge drinking / alcoholism ____
marital status: single __married *children:* ____
____

☑ Nursing Assessment Reviewed. ☐ BP, HR, RR, Temp reviewed.

PHYSICAL EXAM ✓Alert ✓Lethargic __Obtunded

Distress- __NAD __mild ✓moderate __severe

__uncooperative for exam

HEENT
✓nml ENT inspection
✓pharynx nml
if obtunded:
✓nml gag reflex

__depressed / absent gag reflex
__abnormal TM (R / L)
__dry mucosa
__gag reflexed diminished / absent

EYES
✓pupils equal, round & reactive to light
✓EOM's intact

__nystagmus
__disconjugate gaze
__mydriasis / meiosis / anisocoria
R Pupil ____mm L Pupil ____mm

NEURO/PSYCH
mental status
✓mood/affect nml

__slow / no response to commands
withdraws to pain no response to pain
__depressed affect
__tearful / hostile / non-communicative
__suicidal ideation

For suicide attempts: On direct query, patient *ADMITS / DENIES* continued consideration of suicide as an option.
If denies, why?

orientation
✓normal x3

__uncooperative / cannot determine
__disoriented
to: day-of-week day-of-month month year place person

cranial nerves sensory, motor
✓CN's intact as tested
✓nml motor response
✓nml sensory response
__nml reflexes
✓nml gait

__facial droop / CN abnormality
__motor/sensory deficit
__abnormal gait
Ataxic

NECK/BACK
✓normal inspection
✓neck supple

__cerv. lymphadenopathy (R / L)
__thyromegaly / meningismus

RESPIRATORY
✓no resp. distress
✓breath sounds nml

__wheezing
__rales / rhonchi

CVS
✓regular rate, rhythm
✓heart sounds normal

__irregularly irregular rhythm
__extrasystoles (occasional / frequent)
__tachycardia / bradycardia
__JVD

ABDOMEN
✓non-tender
✓nml bowel sounds
✓no organomegaly

__guarding
__hepatomegaly / splenomegaly

SKIN
✓color nml, no rash
✓warm, dry

__cyanosis / diaphoresis / pallor
__skin rash

EXTREMITIES
✓non-tender
✓normal ROM
✓no signs of injury
✓no pedal edema

__laceration
__pedal edema

PROCEDURES: ☐ Restraints
☐ Intubated __by ED physician nasal /oral #____ET tube
__breath sounds equal __tube position confirmed w CXR
☐ Gastric Lavage __*pill fragments recovered*
☐ Charcoal ______gm given Sorbitol ______oz given

Psych Disorder; Overdose-52 Rev. 01/01

LABS, XRAYS, and PROGRESS

EKG MONITOR STRIP __NSR __Rate____

EKG __NML ☐Interp. by me. ☐Reviewed by me Rate____
__NSR __nml intervals __nml axis __nml QRS __nml ST/T
nc / changed from:

CXR ☐Interp. by me ☐Reviewed by me ☐Discsd w/radiologist
__nml/NAD __no infiltrates __nml heart size __nml mediastinum
nc / changed from:

CBC *normal except*	Chemistries *normal except*	ABG's	Toxicology *normal except*
WBC____	Na____	time:	acetamin____
Hgb____	K____		aspirin-____
Hct____	Cl____	pH____	ETOH-____
Platelets____	CO2____	pCO2____	Triage™ urine drug screen-
segs____	BUN____	pO2____	
bands____	Creat____	__RA	
lymphs____	Gluc____	__O2 ____L	
monos____	Anion Gap____		

Pulse Ox ____% on *RA / ____L / ____% at (time)*

Time____ __unchanged ✓improved __re-examined
[illegible handwritten progress notes]

__Rx given [illegible]

INTERVIEW WITH OTHER RESPONSIBLE ADULT: [illegible]
Name: ____ *Relationship:* [illegible]
Considers ongoing suicide risk: high low uncertain [illegible]
Capable / comfortable with observing patient at home? Yes No N/A

MEDICAL CLEARANCE FOR PSYCHIATRIC REFERRAL (if needed)
Back slash to indicate that diagnosis is unlikely based on H&P and, when needed, lab testing.
•Toxic (PCP, Amphetamines, Hallucinogens, Acetaminophen, ASA, ETOH, Other)
•Infectious (Meningitis, Encephalitis, Sepsis)
•Metabolic (Thyroid, Hypoglycemia, Drug Withdrawal, Hypoxemia, Electrolytes)
•CNS Vascular and Other (CVA, TIA, Seizure, Trauma)
•Other Unstable Comorbidities ☐cleared medically for psych referral

✓Discussed with Dr. [illegible] __CRIT CARE- *30-74 min*
will see patient in: office / ED / hospital *75-104 min* 40 *min*
✓Counseled patient / family regarding: ✓Prior records ordered
lab results diagnosis need for follow-up __Additional history from:
__Admit orders written *family caretaker paramedics*

CLINICAL IMPRESSION:
Ethanol Intoxication Psychosis Schizophrenia- *acute exac.*
Depression Drug Overdose (intentional / accidental)
Bipolar *manic* Suicide Attempt / Ideation
[illegible handwriting]

Discharge Instructions [illegible handwriting]

DISPOSITION- ☑ home ☐ admitted ☐ transfer ____
CONDITION- ☐ unchanged ☐ improved ☐ stable

____ NP / PA
[signature] MD / DO

I have personally performed and participated in all the above services (including HPI and PE) and procedures. I have reviewed with the PA/NP the history and have confirmed the findings with the patient.

☑ Template complete ☐ Progress Notes

WALKER
BAPTIST MEDICAL CENTER

EMERGENCY DEPARTMENT RECORD

PATIENT NO.	DATE	TIME	CLINIC 1	VERIFIED BY	ROOM NO.	TYPE	F/C	SPECIALTY	CLERK
9609149-1	07/31/03	02:58	ERRM		ED 02	E	L		JLP

AGE	BIRTHDATE	SEX	RACE	M/S	MOTHER'S MAIDEN NAME	SOCIAL SECURITY NO.	PHONE	COUNTY	MED REC. NO
046	[redacted]	M	W	M	HAGOOD	[redacted]	[redacted]	WALKER	0246796

PATIENT NAME & ADDRESS
BARRON TOMMY
[redacted]

LAST VISIT DATE & TYPE: 07/25/03 ERRM0
ACCIDENT DATE/CAUSE: 07/31/03 PT STATES "
W/C CONTACT:
AUTH. NO.:
ARRIVED VIA: AMBULANCE-OT
RECEIPT NO. & AMT.:

GUARANTOR NAME & ADDRESS
BARRON ,TOMMY
[redacted]

SOC. SEC. NO.: 426-21-7299
PHONE: 205-924-0691

EMPLOYMENT INFORMATION - ONE
REL: 01PATIENT
SOCIAL SECURITY #: [redacted]
PHONE:
STAT:

EMPLOYMENT INFORMATION - TWO
REL: 02SPOUSE
SOCIAL SECURITY #: 426-21-7299
PHONE:
STAT: 3

IN CASE OF EMERGENCY CONTACT (NAME & ADDRESS)
DIANE MCCULLEN/[redacted]
JAN EDWARDS [redacted] FRIEN

RELATIONSHIP:
PHONE:

PHYSICIANS' NUMBERS AND NAMES
1 999995 — SOUTHERN MEDICAL GRO
2
3 000000 — NO FAMILY PHYSICIAN
PCP PHYSICIAN

1. INSURANCE CODE & NAME: 1M60MEDICARE OUTPT
POLICY NO.: [redacted]
GROUP NO.:
PRECERTIFICATION NO.:
SUBSCRIBER NAME & BIRTHDATE: BARRON ,TOMMY

2. INSURANCE CODE & NAME: 2K28MEDICAID 2NDA
POLICY NO.: [redacted]
GROUP NO.:
PRECERTIFICATION NO.:
SUBSCRIBER NAME & BIRTHDATE: BARRON ,TOMMY

3. INSURANCE CODE & NAME:
POLICY NO.:
GROUP NO.:
PRECERTIFICATION NO.:
SUBSCRIBER NAME & BIRTHDATE:

4. INSURANCE CODE & NAME:
POLICY NO.:
GROUP NO.:
PRECERTIFICATION NO.:
SUBSCRIBER NAME & BIRTHDATE:

CHIEF COMPLAINT: CONSULT
CODES:
COMMENTS:

RESULTS
Monitor
EKG
Radiology
Laboratory
Other

Time Examining MD Notified:
Time Patient Examined:
Condition on Arrival: ☐ Satisf. ☐ Fair ☐ Poor ☐ Critical
Chief Complaint:
HPI

Provisional Diagnosis:

Disposition Time: ☐ Discharged ☐ Admitted ☐ Transferred ☐ AMA

Condition On Discharge: ☐ Satisf ☐ Fair ☐ Improved ☐ Poor ☐ Critical

Certified Emergency: ☐ Yes ☐ No

CONSULT	TIME NOTIFIED	RESPONDED	ARRIVED

_____ M.D.
Examining M.D. Signature

BARRON TOMMY
SOUTHERN MEDICAL GRO 07/31/03
MR: 0246796 M W 046
PT: 9609149-1 JLP ED 02 L
WALKER

PATIENT STATUS

(A.) PATIENT ADMITTED**DO NOT DISCHARGE**

1. DIED
2. LAMA (LEFT AGAINST MEDICAL ADVICE)
3. TRANSFERRED
4. DISCHARGED
5. LEFT BEFORE SEEN
6. BMC NOT INSURANCE PROVIDER

ICU - 1
Dr Chadwick
alcohol + benzo OD.

PHYSICIAN _____

DISCHARGE TIME _____

CERTIFIED EMERGENCY YES OR NO

(MEDICAID ONLY) _____

N
N
G

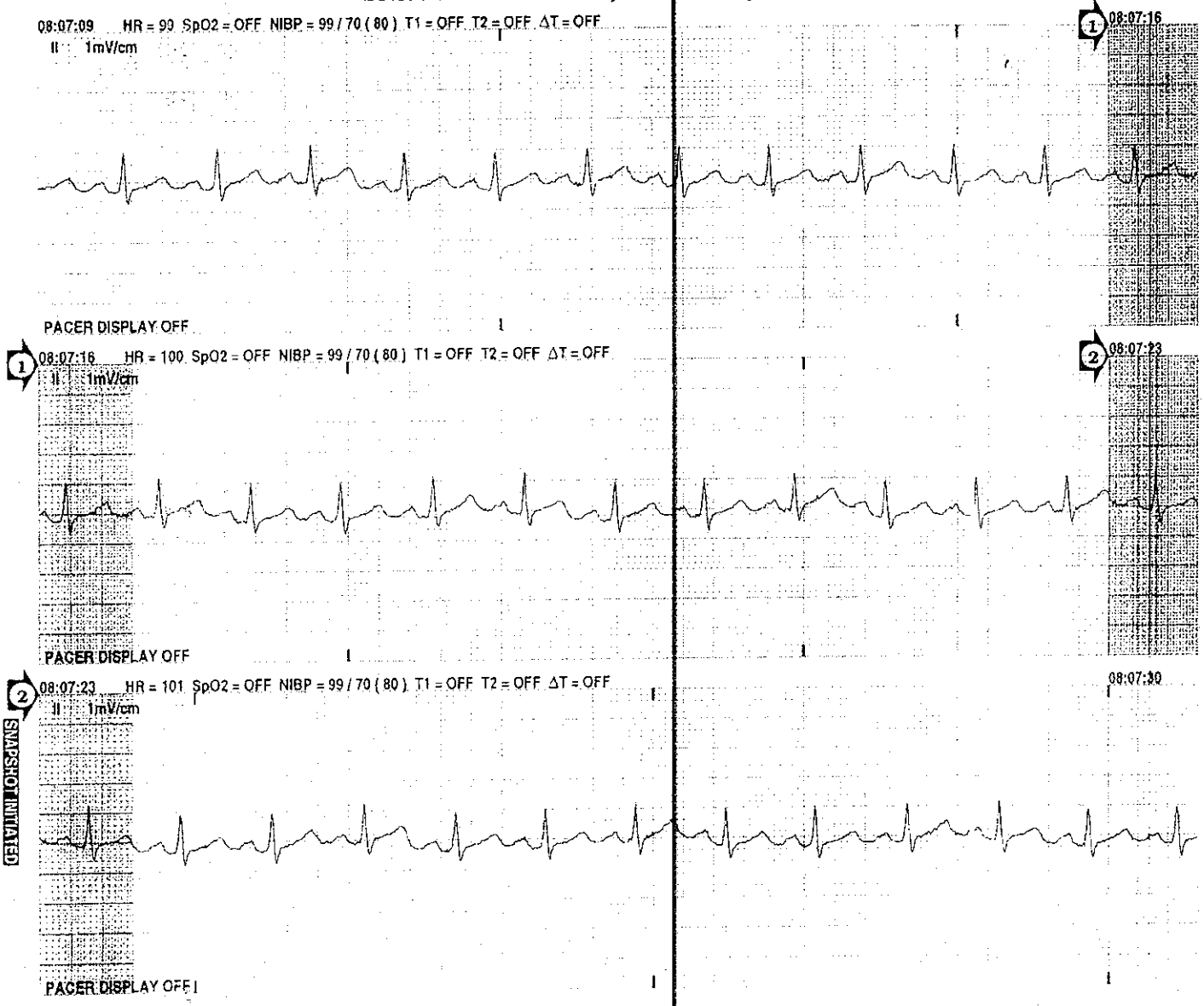
CO-PAY OR EMERGENCY DEPARTMENT FEE
DUE AT END OF VISIT

WC-02-5018 REV 12/7/02 P

Thursday 31-July-2003 08:07:09 **Walker Baptist Medical Center** ACUITY

TOMMY BARRON	96091491	ED 18

SNAPSHOT 25 mm/sec Adult/Pediatric



Vital Signs Summary		
Time	Sys / Dia (Mean)	HR/PR
HH:MM	-- mmHg (NIBP) --	BPM
06:05	98 / 77 (85)	87
06:39	78 / 52 (61)	87
07:16	99 / 56 (67)	87
07:30	89 / 60 (68)	91
07:45	93 / 61 (75)	94
08:00	99 / 70 (80)	100

Comments

WALKER
BAPTIST MEDICAL CENTER

Emergency Department
ORDER FORM

BARRON **TOMMY**
SOUTHERN MEDICAL GRO 07/31/03
MR: **0246796** M W 046 [redacted]
PT: **9609149-1** JLP ED 02 L 18

MEDICATION / TREATMENT / RESPONSE

TIME	MEDICATION / TREATMENT	DOSE	ROUTE	SITE	INITIAL	TIME	PATIENT RESPONSE	INITIAL
0345	Narcan	2mg	IM	LGM	DMB			
0346	Thiamine	100mg	IV	IV	DMB			
0515	Romazicon	0.2mg	IV	IV	[illegible]	[illegible]	[illegible]	

MD ORDERS

TIME	MD ORDERS
	NS 2 liters
	Narcan 2 mg IM
	Mag Sulfate 2 g IM
	Thiamine 100 IV
	½ Romazicon 0.2 mg IVP, if no response
5 min	0.3 mg IVP — [illegible]
	[illegible]

INTERVENTIONS/ORDERS

EXP/Lot. No.

- ☐ B/P Monitoring
- ☐ IV
- ☐ Hep Lock
- ☐ Oxygen
- ☐ Pulse OX
- ☐ Telemetry

TD 0.5 MI IM

LABORATORY Blood sent - DMB

ORDERED / COMPLETED: 0548

TEST

- ☑ CBC: WBC ____ HGB ____ PLT. CT ____ HCT ____ SEG ____ B ____
- ☐ Cardiac Enzymes: CK ____ MI ____ CKMB% ____
- ☐ Troponin ____ ☐ CPK ____
- ☐ PT ____ PTT ____ INR ____
- ☐ BMP: Na ____ K ____ Cl ____ CO2 ____ BUN ____ Creat ____ AG ____ Glucose ____ Ca ____ Osmo ____
- ☑ CMP BMP (Above) + Hepatic Function Panel (Below)
- ☑ Hepatic Function Panel Albumin ____ Total Protein ____ Bilirubin ____ Bili Direct ____ Alk Phos. ____ SGOT ____ SGGT
- ☐ Amylase ____ ☐ Lipase ____
- ☐ Theophylline ____ ☐ Dilantin ____
- ☐ Digoxin ____ ☐ Phenobarb ____
- ☐ UA SPGR ____ WBC ____ RBC ____ Gluc ____ Ket ____ Bact ____ Nitrate ____
- ☐ Urine Culture ☐ Cath ☐ CCV ☐ Urine Pregnancy (0330)
- ☑ Urine Drug Screen ☐ ETOH (1-2)
- ☐ Serum Pregnancy ☐ Neg ☐ Pos ☐ Quant
- ☐ Rapid Strep ☐ Throat Culture ☐ Mono Spot
- ☐ Blood Culture x ____
- ☐
- ☐

VITAL SIGNS

TIME	TEMP	PULSE	RESP.	B/P	PULSE OXIMETRY	NURSE SIGNATURE/TITLE

See Vital Signs Flow Sheet

RADIOLOGY Time To ____ Time From ____

IV FLUIDS

TIME	NO	TYPE	AMT	RATE	CATH	ROUTE/LOC	NO. OF STICKS	NURSE INIT
0330	1	NS	1	WO	20g	RA	1	DMB
↳	2	NS	2	WO				

RESPIRATORY

- ☐ ABG PH ____ CO2 ____ PO2 ____ SAT ____
- ☐ Breathing Treatment Medication ____
- ☐ EKG ☐ NSR Rate ____ ☐ ABNL ____
- ☐

NURSE DISCHARGE CHECKLIST: ☐ Tetanus Given ☐ IV Site Checked ☐ Valuables Checklist ☐ Antibiotic Given

CERTIFIED EMERGENCY ☑ YES ☐ NO

DIAGNOSIS: ☑ SEE T. SHEET OTHER ____

DISPOSITION: ☒ Discharged ☐ 23 Hr Obs. ☒ Admit to Rm./Unit: ICU ☒ Report to Time: Regina 0820

☐ Transfer to Hosp./Fac. ____

METHOD OF LEAVING ED: ☐ Ambulatory ☑ Stretcher ☐ Wheelchair ☐ Crutches ☑ AMA ☐ Carried ☐ Amb./Helicopter

☐ OBSERVATION @ Time ____ ☐ Chest Pain Bed ☐ Stroke Bed ☐ Critical Care Bed ☐ ICU - Bed ☐ Other ____

DISCHARGE INSTRUCTIONS: ____

☐ Return to Emergency Department as Needed ☐ F/U with MD in ____ or if needed.

CONDITION AT DISCHARGE: ☐ GOOD ☐ POOR ☐ FAIR ☐ DECEASED

PATIENT D/C INSTRUCTIONS GIVEN: ☐ Head Injury Sheet ☐ Wound Sheet ☐ Fever Sheet ☐ Crutch Precautions ☐ Sprain/Bruise Sheet ☐ Eye Patch Sheet ☐ Clear Liquid Sheet ☐ TAB Sheet ☐ Instructed Not to Drive Due to Sedation ☐ Instructed to Wait 15 Minutes After Injection/PO MED ☐ RX ☐ Written Patient Instructions ☐ See Nurse's Notes

DISCHARGE TIME: 8:30

Physician's Signature: [signature]

Discharge Nurse Signature: [signature]

REV 4/01 WBMC-6300-03-PG/C-122041

TRIAGE NAME Barron, Tommy AGE 46 DATE 7/31/03

EMERGENCY DEPT. TRIAGE FORM

BARRON TOMMY
SOUTHERN MEDICAL GRO 07/31/03
MR: 0246796 M W 046 [redacted]
PT: 9609149-1 JLP ED 02 L

ROOM #	TIME IN ROOM	EMERG.	URGENT	SEMI-URGENT	NON-URGENT	RECHECK ☐ Scheduled ☐ Non-Scheduled
78	0252		✓			

ACCOMPANIED ON ARRIVAL BY: ☐ SELF ☐ RELATIVE ☐ OTHER ☐ TRANSFER FROM ________ HOSP
NOTIFIED: Police ☐ Family ☐ Coroner ☐ Time: ______

MODE OF ARRIVAL: ☐ PRIVATE VEHICLE ☑ AMBULANCE ☐ AMBULATORY ☐ WHEELCHAIR ☐ CARRIED ☐ POLICE ☐ OTHER ☐ CRUTCHES ☑ STRETCHER

FAMILY M.D. none
SIGN IN TIME
Have you seen an M.D. in the last 24 hours? Y ☐ N ☐
Call Light ☑
Side Rail Up ☑
Valuables: ☐ Y ☐ N ☐ See Valuables Checklist

AREA ☐ MAIN ED: ☐ TRAUMA ☐ Major ☐ Minor ☐ MEDICAL ☐ Cardiac ☐ Non-Cardiac ☐ FAST TRACK: ☐ GYN ☐ EENT ☐ ORTHO ☐ Other ______

CHIEF COMPLAINT c/o "pain" states wants to be admitted to Bren

TREATMENT PRIOR TO ARRIVAL: ☐ None
Medication: ______ Time ______
Other: ______

Prehospital Care:
☐ None ☐ Ice ☐ Elevate
☐ Spinal Immob. ☐ Splint ______
☐ C-Collar ☐ IV ______
☐ Dressing ______ ☐ O₂ ______

PAST MEDICAL HISTORY ☐ Non-significant PMH ☐ AMI Date ______ ☐ CHF
☐ HTN ☐ CABG ☐ CAD ☐ ASCVD ☐ Diabetes ☐ PUD
☐ CRF ☐ COPD ☐ Asthma ☐ Sz Disorder Use ☐ Arthritis ☐ Ca
☐ CVA ☐ Sickle Cell ☐ HIV ☐ Hepatitis ☐ Liver Disease
☐ Migraine ☑ Other: Back pain
Weight ______ ☐ Tobacco use no ☐ Alcohol use no

ALLERGIC TO DRUG ☐ YES ☑ NO LIST: ______
FOOD ☐ YES ☑ NO LIST: ______

PRESENT MEDICATIONS NONE ☑ SEE HOME MED SHEET ☐ SEE NURSING HOME LIST ☐
Tetanus ☐ U.T.D. ☑ unknown ☐ > 5 years

VITAL SIGNS

Time	Pulse	Resp.	B/P	Temp T R P O	Pulse Ox
0252	91	18	93/67	96.1	98

ASSESSMENT

RESPIRATORY
☐ Not applicable
☑ Normal bilateral
☐ labored
☐ rales/rhonchi
☐ wheezing R L
☐ retractions
☐ nasal flaring
☐ decreased R L
☐ Cough
☐ non-productive
☐ productive
☐ sputum color ______
☑ airway clear
☐ part. obstructed
☐ obstructed

CARDIO-VASCULAR
☑ Not applicable
☐ Pulse regular
☐ irregular
☐ Skin W & D
☐ cool & clammy
☐ Skin pink/normal
☐ pale
☐ cyanotic
☐ flushed
☐ jaundiced
☐ rash
☐ Cap refill <2 sec.
☐ >2 sec
☐ Pulses intact
☐ Edema
☐ JVD

NEUROLOGICAL
☐ Not applicable
☑ cooperative
☐ uncooperative
☐ agitated/combative
☐ oriented
☐ disoriented
☐ inappropriate
☐ sleeping
☐ Reported LOC
Min ______
☐ alert/playful
☐ crying
☐ irritable

GASTROINTESTINAL
☐ Not applicable
☑ Bowel sounds present
Abdominal
☑ Soft ☐ Firm
☐ Nondistended ☐ Distended
Abdominal Tenderness
☐ Yes ☑ No
☐ Rebound Last BM ______
Diarrhea ☐ Yes ☑ No
Vomiting ☐ Yes ☑ No

GENITOURINARY
☑ Not applicable ☐ Dysuria
☐ Frequency ☐ Discharge
☐ Swelling ______
☐ Hx of Bleeding ______
☐ LMP ______

HYDRATION STATUS
☐ Not applicable
Mucous Membranes:
☑ Moist ☐ Dry
Eyes
☑ Normal ☐ Sunken
Skin Turgor:
☐ Poor ☑ Normal

Neck
☑ Not Applicable
☐ Supple
☐ Other

Pupils
☐ Not Applicable
Acuity
R L
mm Size mm
Brisk
Sluggish
Fixed

FONTANELLES ☐ N/A > 19 mon
☐ flat ☐ bulging
☐ depressed

GROWTH & DEVELOPMENT
Personal-Social ☑ WNL no
Fine Motor ☑ WNL no
Language ☑ WNL no
Gross Motor ☑ WNL no

PEDIATRIC IMMUNIZATION:
☐ UTD
☐ NUTD*
Head Circum ______
☐ N/A > 36 mon
Birth Weight ______

SKIN/EXTREMITY
☐ Not Applicable
☐ Wound/Injury (Describe)

Fall Precaution: ☐ Yes ☑ No
Green Armband On: ☐ Yes ☑ No
At Risk for Skin Breakdown: ☐ Yes ☑ No
Advance Directive ☐ Yes ☑ No
DNR ☐ Yes ☑ No

NEUROLOGICAL GLASGOW COMA SCALE
Eyes 4
Verbal 5
Motor 6
TOTAL 15

PUPILS (mm) KEY
1 2 3 4 5 6 7 8

PAIN ASSESSMENT

☐ NONE ☑ CURRENTLY HAVE PAIN ☐ PAIN IN LAST 6-8 WEEKS
LOCATION: Chronic back pain
ONSET Chronic QUALITY: ______ ☐ CONSTANT ☐ INTERMITTENT
WHAT HAS RELIEVED YOUR PAIN? PAST: ______ CURRENT: ______
CURRENT PAIN LEVEL: NEONATE (0-10) ______ INFANT/CHILD (0-5) ______ ADULT (0-10) 8

Pain Intensity (VAS or FACES)
0 NO HURT, 1 HURTS LITTLE BIT, 2 HURTS LITTLE MORE, 3 HURTS EVEN MORE, 4 HURTS WHOLE LOT, 5 HURTS WORST

VAS Rate Pain and effectiveness on scale 0 = no pain & 10 = worst pain
0 1 2 3 4 5 6 7 (8) 9 10

NUTRITION SCREEN

☐ No Apparent Problem ☐ Teeth Intact ☐ Missing Teeth ☐ Toothless
☐ Poor Appetite ☐ Emaciated Appearance ☐ Obese Appearance ☐ Unintentional Weight Loss (>10 lbs in last 3 months)
☐ Pregnancy ☐ Lactating ☐ Anemia ☐ Eating Disorder

FUNCTIONAL SCREEN

☐ Difficulty performing ADLS without assistance or special aids: ______
☐ Problems with balance or mobility: ______
☐ Difficult speech; chewing or swallowing problems ☐ Visual impairment

ASSESSMENT KEY

	INFANT / TODDLER (GCS) GLASGOW COMA SCALE			CHILDREN /ADULT GLASGOW COMA SCALE	
EYE OPENING	SPONTANEOUS	4	EYE OPENING	SPONTANEOUS	4
	TO SPEECH	3		TO VOICE	3
	TO PAIN	2		TO PAIN	2
	NONE	1		NONE	1
VERBAL RESPONSE	SMILES, INTERACTS	5	VERBAL RESPONSE	ORIENTED	5
	CONSOLABLE	4		CONFUSED	4
	CRIES TO PAIN	3		INAPPROPRIATE WORDS	3
	MOANS TO PAIN	2		INCOMPREHENSIBLE WORDS	2
	NONE	1		NONE	1
MOTOR RESPONSE	NORMAL, SPONT MOVEMENT	6	MOTOR RESPONSE	OBEYS COMMAND	6
	LOCALIZES PAIN	5		LOCALIZES PAIN	5
	WITHDRAWS TO PAIN	4		WITHDRAWS TO PAIN	4
	ABNORMAL FLEXION	3		FLEXION (PAIN)	3
	ABNORMAL EXTENSION	2		EXTENSION (PAIN)	2
	NONE	1		NONE	1

☐ SEE TRAUMA FLOW SHEET ☐ SEE CODE SHEET

Triage [signature] R.N.

WBMC 6300-02-WALLACE

PSYCHOSOCIAL STATUS / EDUCATION

Are there any religious, traditional, ethical or cultural practices that need to be a part of your care?

☐ Yes ☒ No

Specify: _____

Are you being hit, hurt or frightened by anyone in your home life?

☐ Yes ☒ No

How do you learn best? ☐ Verbal ☐ Reading ☒ Demonstration

What interferes with your learning? ☐ Physical ☐ Age Related ☐ Communication ☐ Language

☐ Spiritual ☐ Cultural ☐ Hearing ☐ Visual ☐ None ☐ Religious

INTERVENTIONS

☐ Tylenol _____ mg. Time _____

☐ Ibuprofen _____ mg. Time _____

☐ Wound Cleansed _____

_____

☐ NPO - Explained at Triage

☐ C-Collar

☐ Dressing _____

_____

_____

☐ Ice & Elevation

☐ Immobilization

☐ Isolation Mask

CONSENT AND AUTHORIZATION

I am presenting myself for diagnosis and treatment at the Walker Baptist Medical Center and I consent to the rendering of such care, including diagnostic procedures, surgical and medical equipment, and blood transfusions, by authorized members of the hospital medical staff or their designees, as may in their professional judgement be necessary. I acknowledge that no guarantees have been made to me as to the results of such examinations or treatment on my condition.

Undersigned hereby authorizes the Walker Baptist Medical Center and my Physician(s) to release to my insurors full information (including copies of records) relative to this hospitalization.

X _____

PATIENT/PARENT/RESPONSIBLE PARTY SIGNATURE

_____

RELATIONSHIP TO PATIENT

WALKER BAPTIST MEDICAL CENTER

CONSENT FOR TREATMENT

BARRON **TOMMY**
SOUTHERN MEDICAL GRO 07/31/03
MR: **0246796** M W 046 [redacted]
PT: **9609149-1** FC: L ED 02

(Addressograph)

CONSENT OF HOSPITAL SERVICES: Consent is given to Walker Baptist Medical Center, Radiology Associates of North Alabama, P.C., Southern Medical Group, Inc., Foothills Anesthesia P.C., and Baptist Health Clinics, its contractors and its employees to provide hospital services and administer physician orders. Certain procedures may require separate consents. Physicians are responsible for explaining medical or surgical procedures, and patients may be called following their procedure for quality and continuum of care. The undersigned authorizes observers to be present during treatment/surgery for purposes of medical training and education.

PHYSICIANS: Physicians including, without limitation, Southern Medical Group Inc., Radiology Associates of North Alabama, P.C., Foothills Anesthesia, P.C., and Baptist Health Clinics, and Inpatient Medical Services.

(P) Patient unable to sign
Consent for treatment (by patient or authorized representative)

7.31.03
Date

Amanda Kilpatrick
Witness

BARRON **TOMMY**
SOUTHERN MEDICAL GRO 07/31/03
MR: **0246796** M W 046 [redacted]
PT: **9609149-1** FC: L ED 02

(Addressograph)

WALKER BAPTIST MEDICAL CENTER

CONDITIONS OF ADMISSION PRIVACY NOTICE AND FINANCIAL RESPONSIBILITY

PERSONAL VALUABLES: The Walker Baptist Medical Center is not responsible for money, jewelry, dentures, hearing aids, eye glasses, watches, credit cards, end such other items which are not deposited in the Hospital safe.

AUTHORIZATION TO RELEASE INFORMATION: The undersigned authorizes the Walker Baptist Medical Center and any physician rendering service, for example,Radiology Associates of North Alabama, P.C., Southern Medical Group, Inc., Foothills Anesthesia, P.C., and Baptist Health Clinics, Inc., to release medical or other information about the patient which may be necessary for the completion of insurance claims, review of services, or receipt of benefits. Such information may include current medical records. The information may be released to third-party payors, including the third-party payor's agent and/or representative or anyone responsible for payment of hospital and/or physician charges.

ASSIGNMENT OF BENEFITS: The undersigned assigns to and authorizes direct payments of benefits (including insurance benefits, otherwise payable with respect to the patient) to the Walker Baptist Medical Center, Southern Medical Group, Inc., Radiology Associates of North Alabama, P.C., Foothills Anesthesia P.C. and Baptist Health Clinics, Inc. The undersigned agrees to assist in processing claims for benefits.

MEDICARE AUTHORIZATION: I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request payment of the authorized benefits be made on my behalf to the Walker Baptist Medical Center, Southern Medical Group, Inc., Radiology Associates of North Alabama, P.C., Foothills Anesthesia P.C. and Baptist Health Clinics, Inc. or any physician rendering services during my treatment.

FINANCIAL RESPONSIBILITY: The undersigned agrees to pay for the hospital services, accommodations and physician services rendered to patient and is hereby obligated to pay the accounts of the hospital. It is understood that in the event of obstetrics care the undersigned is obligated to pay the hospital account for mother and infant(s). It is understood and agreed that Walker Baptist Medical Centers, charges not paid may be placed with any attorney or a collection agency. It is understood and agreed that reasonable cost of collection including attorney fees, collection agency fees, and/or open account interest charges assessed are payable by the undersigned. To the extent not expressly prohibited by applicable law, the undersigned agrees to pay all hospital charges not paid in full to the hospital by a third-party payor. The Walker Baptist Medical Center accepts cash, Mastercard, Visa, Discover Card.

The undersigned is aware that in some cases the patients hospital bill may not be covered in full by the insurance company. The undersigned is aware of the fact the (patient/responsible party/guarantor) are responsible for any balance insurance does not pay. This balance due may include provisions set by your insurance company such as: co-payments, deductibles, and "usual and customary" allowances. Co-payments, and deductibles are due upon admission and must be paid prior to discharge.

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND ITS PURPOSE AND CONTENT.

Patient unable to sign
Guarantor (Agreement to Pay)

I have received the BHS privacy notice

Refused the privacy notice

7.31.03
Date

Amanda Kilpatrick
Witness

CONDITIONS OF ADMISSION AND PRIVACY ACKNOWLEDGMENT